Editorials

Physician-Subsidized Health Care

ELSEWHERE IN THIS ISSUE an admittedly less than perfect study provides some insight into the extent to which physicians, at least in San Francisco, think they are subsidizing health care in their community. Even if the figures are substantially overstated and by a self-selected segment of the physician population in San Francisco, they are impressive. They also suggest how far we have drifted from the loudly proclaimed social goal of the 1960s, which was to eliminate "demeaning" charity from patient care. Charity in health care has continued to be with us. No one thinks that it was ever completely eliminated.

In any case, these are the 1980s, soon to be the 1990s, and the resources for needed charity are coming under severe strain. The social programs that were expected to eliminate "demeaning" charity and assure dignity in health care regardless of the ability to pay have simply failed to do this. More and more of the third-party payers in both the public and private sectors are either unwilling or unable to pay the true costs of patient care. Paradoxically, the human and technologic resources for health care exist in relative abundance—certainly this is true in San Francisco—but there are not sufficient dollars to pay for care that is presently uncompensated yet needed. The burden of taking care of those who cannot pay the real costs is being carried by the charity that community hospitals, practicing physicians, and others in the health care field are willing and fiscally able to provide. It seems more and more evident that the fiscal capacity for this charity is limited and may soon be exceeded by the need for it.

There are recognizable, inescapable basic costs to rendering uncompensated care, and if these costs cannot somehow be met, there will be no uncompensated care, no matter how good the intentions are of those who would want to provide it. The fiscal squeeze has been on hospitals, physicians, and local communities for some time now, and in certain programs for the needy the costs of rendering care have already begun to exceed the revenues available to pay those costs. The fat is now pretty well out of the system, and there are signs that the bone and the muscle are beginning to be cut away.

As one ponders this prospect of inadequate or unavailable health care for those who may need it most, one wonders if a way might be found to make whatever dollars are available for indigent care more readily available to be used more efficiently where the care is needed—that is, in the local communities or perhaps in some kind of community-based health care regions, possibly under the jurisdiction of a community or regional authority that would be relatively free of inefficient and costly interference and restriction from state and federal governments. As it is, the sources of the dollars are all far from the real human action in health care. Federal and state programs have now been shown not to meet the need. Perhaps their administration and control have been just too remote to be able to function efficiently and effectively at a local level, where health care dollars could be applied in response to human needs and within a framework of human relationships. Maybe it is time to streamline the system and give decentralized local communities and health care regions more of the financial resources and more responsibility for how they are spent, and thus allow them a better chance of solving their own problems in what might prove to be more sensitive ways.

MSMW

Medicare Payment Reform—A Practitioner's Perspective

AS THE PHYSICIAN PAYMENT REVIEW COMMISSION attempts to find ways to restructure Medicare financing for physicians' services, the perceptions of practicing physicians and the way in which they are paid for the work they do tend to vary with their specialty. All parties have many axes to grind. Consequently, Lee and Ginsburg have their work cut out for them if they are to truly build a consensus on the Medicare payment reform they discuss elsewhere in this issue.

Questions of physician payment tend to arouse powerful emotions within and outside of medicine. It is sobering to think that in the last months of 1987, underpaid physicians in Peru struck for higher wages and were teargassed after throwing rocks during a clash with the police. In several countries there are physicians who cannot find a job or who must move to remote areas in order to earn a living wage.

Physicians in the United States have been lucky, but, then again, so have many other Americans. The 1987 average remuneration (salary and fringe benefits) for industrial workers in this country reached $50,000 a year. The average physician now earns more than double that amount. But the average primary care physician does not.

Medicare has been a major contributor to physicians' incomes. In retrospect, the opposition of the American Medical Association to the creation of Medicare seems extraordinary. Few, if any, other "industries" would have rejected such largess, especially since the burden of charitable care had also been removed with the creation of Medicaid. The much-feared concurrent government regulation has also been much slower in coming than many would have predicted.

The climate in which medicine is practiced has changed. The 1965 blend of charitable and fee-for-service care has yielded to the 1988 fixation on the bottom line. There is more money but less honor in medicine. And there are nearly 40 million Americans without any health insurance. At the same time, the approach toward physicians has changed. We are increasingly being viewed as economic animals to be manipulated into compliance by each and every program of the moment: from healer to puppet in a little more than 20 years.

Medicare sends confusing signals. There is more pay for a home visit by a nurse than by a physician. Chiropractic adjustments constituted the ninth most common service paid by Medicare in 1983—procedures for which there is public demand but with little in the way of agreement regarding necessity, utility, or quality. Preventive medicine is not covered by Medicare, but the National Institutes of Health continue to promote it vigorously.

Fee-for-service practice is now burdened with administrative requirements that force an increasing amount of both physician and staff time to be directed away from patient care. Examples are the explanation of maximum allowable actual